DEPARTMENT OF HEALTH SERVICES
P.O.BOX 942732
SACRAMENTO, CA 94234-7320
(916) 323-1945

Dear Durable Medical Equipment Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Currently there is a 180-day moratorium on the enrollment of applicants in the Medi-Cal program as Durable Medical Equipment (DME) providers. This moratorium ends on April 13, 2002. This is in accordance with Section 14043.55 of the California Welfare and Institutions Code. As stated in the Welfare and Institutions Code, this moratorium may be extended or repeated when the Director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

This means Medi-Cal is not accepting applications for enrollment of new providers of durable medical equipment. However, if your business deals exclusively in custom wheelchair sales or rental, or wheelchair repair, or you request enrollment as Medicare crossover only, reimbursement for only Medicare cost sharing amounts, you may be eligible to submit an application. Further, if you are currently enrolled as a Medi-Cal DME provider, you may be eligible to submit an application for changes to your location or expansion.

If you meet the criteria outlined above and wish to enroll as a provider of services for Medi-Cal beneficiaries, please complete the enclosed forms and return them to this office. Please include a cover letter with your application package explaining in detail what you are requesting. If your business does not fall under one of these exceptions, please contact our office in early April 2002 to ascertain the status of the moratorium.

Instructions for completion of these documents are included with the forms. Please read the instructions carefully and complete each item requested. Application packages received that are incomplete will be returned. Questions regarding completion of the application, disclosure statement and/or provider agreement should be directed to the Provider Enrollment Branch at (916) 323-1945 between 8 a.m. and 5 p.m.

It is your responsibility to report to the Department of Health Services any changes to information previously reported on the enrollment documents within 35 days of the change. Most changes may be reported on a Medi-Cal Supplemental application. You may request a Medi-Cal Supplemental application by contacting Electronic Data Systems Corporation at 1-800-541-5555. If however, you are reporting a change of ownership of 50 percent or more or a change of business address and you sell incontinence medical supplies, you must complete a new application package.

For more information on the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our website at www.Medi-Cal.ca.gov and click on Provider Enrollment.

If you have any questions, please call our office at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

MEDI-CAL DURABLE MEDICAL EQUIPMENT PROVIDER APPLICATION

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check one) | Date

❒ New provider

❒ Change of ownership—Current Medi-Cal provider number: _____

❒ Additional business address—Current Medi-Cal provider number: _____

❒ Continued enrollment (Check this only if you have been requested by the Department to apply for continued participation in the Medi-Cal program pursuant to Title 22, California Code of Regulations, Section 51000.55.)—Medi-Cal provider number: _____

Type of entity

❒ Sole proprietor ❒ Partnership ❒ Government

❒ Corporation: ❒ Limited liability corporation: ❒ Other: _____

Corporate number: _____ Corporate number: _____

State incorporated: _____ State incorporated: _____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement number

Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)

4. Business address (number, street)	City	County	State	Nine-digit ZIP code
5. "Pay to" address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code
6. Mailing address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code

7. Federal Employer Identification Number (FEIN)
(Attach a legible copy of the IRS form.)

____ ____ – ____ ____ ____ ____ ____ ____ ____

8. Social security number or Individual Taxpayer Identification Number (ITIN)
(If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of the ITIN verification, if applicable.)
(See Privacy Statement on page 3.)

____ ____ ____ – ____ ____ – ____ ____ ____ ____

9. Any local business license numbers/permits (attach legible copies)	10. Medicare billing number	11. Seller's Permit number (attach a legible copy)

12. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies and/or medical supply items? ❒ Yes ❒ No

If no, please explain: _____

_____

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Are your equipment and/or supplies:

❒ A. In stock on the premises, or

❒ B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation:

Days: _____ Hours: _____

If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code

Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	ZIP code

13. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give the percentage of each business activity in which the applicant or provider engages in. Total the percentages at the end of this question. Percentages must total 100 percent. (Include licensure information of applicable business activities.) Please see instructions for computing percentages.

A. ❒ Beds* ❒ Rental ❒ Sales (if the business sells AND rents beds, check both boxes.) _____%

B. ❒ Wheelchairs* _____%

*Bureau of Home Furnishings and Thermal Insulation license:

If you rent beds, your license must bear a registry number. If it does not, please call the Bureau at (916) 574-0280 for instruction. If you checked bedding and wheelchairs, you must have a Furniture and Bedding License. Any questions must be directed to the Bureau at the above number.

Furniture and Bedding or Furniture Retailer License number (attach a legible copy): _____

Issuance date: _____ Expiration date: _____

C. ❒ **Ostomy supplies (describe): _____ _____%

D. ❒ **Oxygen/oxygen therapy equipment and supplies (describe): _____ _____%

E. ❒ **Urinary catheters, bags, etc. (describe): _____ _____%

**Medical Device Retailer license number (attach a legible copy): _____

Issuance date: _____ Expiration date: _____

**Medical Device Retailer Exemptee license number (attach a legible copy) _____

Issuance date: _____ Expiration date: _____

F. ❒ Orthotic/prosthetic appliances (describe): _____ _____%

G. ❒ Incontinence medical supplies (describe): _____ _____%

You must comply with Article 3.7 of the Welfare and Institutions Code. If you are not selling incontinence supplies, enter zero (0) in the percentage column.

H. ❒ Infusion equipment and supplies (describe): _____ _____%

I. ❒ Other (describe): _____ _____%

TOTAL _____%

Information About Individual Signing This Application

14. Printed name of individual signing this application (last) (first) (middle)		***FOR STATE USE ONLY***
15. Gender ❒ Male ❒ Female	16. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	
17. Date of birth	18. Social security number (***Optional***—see Privacy Statement below.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____	

19. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of the person authorized to bind the applicant or provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

20. Notary Public

Privacy Statement
(Civil Code, Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a), and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

INSTRUCTIONS FOR COMPLETION OF THE DURABLE MEDICAL EQUIPMENT PROVIDER APPLICATION

DO NOT USE correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation. Applicants may be subject to an onsite inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application, the attached disclosure statement and a provider agreement must also be completed for enrollment or continued enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enrollment Action Requested (check one); enter the date you are completing the application.

“New provider” means the applicant is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

“Change of ownership” means the ownership of the applicant or provider has changed by 50 percent or more.

“Additional business address” means the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

“Continued enrollment” means the provider is currently enrolled in the Medi-Cal program and would like to continue participation. Enter the provider number that you would like to continue to use. (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Regulations Section 51000.55.)

“Type of Entity”: Check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. “Legal name” means the name listed with the Internal Revenue Service (IRS).

2. “Business name” means the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement to the application.

3. “Business telephone number” means the primary business telephone number used at the business address. A beeper number, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.

4. “Business address” means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.

5. “Pay to address” means the address to which the applicant or provider wishes to receive payment. The “pay to address” should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.

6. “Mailing address” is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.

7. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or form 2363.

8. If the business is a sole proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification number (ITIN) of the Sole Proprietor. Attach a copy of the ITIN verification, if applicable.

9. Insert any local business license numbers or permits for any city or county or city and county where you conduct your business activities and attach copies to the application.

10. Insert the Medicare billing number.

11. Insert the Seller’s Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller’s Permit.

12. Check the appropriate boxes and complete all requested information in this question.

13. Check the applicable business activities of the applicant or provider and give the percentage of those activities. Attach copies of all applicable licenses and/or certifications. Total the percentages. The percentages must total 100 percent. Calculate percentages based upon total dollar sales, including Medi-Cal, Medicare, all other third party payors, and cash transactions for the year immediately preceding filing of this application. If a change of 20 percent or more in total business activity is anticipated within the next year, compared to business activity in the year immediately preceding the filing of this Application, adjust the percentage listings to reflect this anticipated change.

14. "Printed name of the individual signing the application." Enter the last, first, and, middle name of an individual acting on behalf of and with the authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Services for enrollment.

15. Check (✓) the gender of the individual named in number 14.

16. Provide the driver's license or state-issued identification number and state of issuance of the individual listed in number 14. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

17. Enter the date of birth of the individual named in number 14.

18. Provide the social security number of the individual named in number 14. Provision of the social security number is optional (see Privacy Statement on page 3).

19. An original signature of the individual named in number 14 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

20. The application must be notarized by a Notary Public. The Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Fictitious Business Name Statement
- ❒ FEIN or ITIN verification
- ❒ Seller's Permit
- ❒ Any local business license numbers/permits
- ❒ Bureau of Home Furnishings and Thermal Insulation license
- ❒ Medical Device Retailer license
- ❒ Medical Device Retailer Exemptee license
- ❒ Driver's License or state identification card of individual signing the application